NOTICE OF PROPOSED CHANGES IN THE REGULATIONS OF THE
OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Title 22. Office of Statewide Health Planning and Development

ACTION: Notice of proposed rulemaking.

SUBJECT: **Changes to the *Accounting and Reporting Manual for California Hospitals,* Second Edition.**

PUBLIC PROCEEDINGS:

NOTICE IS HEREBY GIVEN that the Office of Statewide Health Planning and Development (hereafter the "Office") proposes to amend the text of the *Accounting and Reporting Manual for California Hospitals*, Second Edition, as amended December 5, 1996 (hereafter the "Manual"), Section 97018 of Title 22 of the California Code of Regulations which incorporates the Manual by reference, and Section 97041 of Title 22 of the California Code of Regulations which describes the report procedure for the Hospital Annual Disclosure Report and Hospital Quarterly Financial and Utilization Report.

AUTHORITY AND REFERENCE:

The Office of Statewide Health Planning and Development, pursuant to Section 128810 of the Health and Safety Code, has the authority to implement, interpret, or make specific Sections 128735, 128740, and 128760 of the Health and Safety Code.

WRITTEN COMMENT PERIOD:

NOTICE IS ALSO GIVEN that no public hearings will be held. However, interested parties may submit written comments presenting statements, arguments, or contentions relating to the proposed action. All comments must be received by the Office by 5:00 p.m. on August 3, 1998, which is designated as the close of the written comment period. However, a public hearing will be held if, no later than 15 days prior to the close of the written comment period, an interested person submits a written request to hold a public hearing to the Contact Person (see Contact Person and address below).

CONTACT PERSON:

Inquiries and comments concerning the proposed Manual changes may be addressed to Jay R. Benson, Manager, Accounting and Reporting Systems Section, Office of Statewide Health Planning and Development, 818 K Street, Room 400, Sacramento, California 95814 (telephone: 916-323-7676).

INFORMATIVE DIGEST/PLAIN ENGLISH OVERVIEW:

The Health Data and Advisory Council Consolidation Act of 1984 (California Health and Safety Code Sections 128675 through 128815) requires OSHPD to maintain a uniform system of accounting for non-federal California hospitals and that all such hospitals use that system in their books and records on a day-to-day basis. As part of its responsibility to maintain a uniform hospital system of accounting, OSHPD is obligated to update that system to meet the current accounting needs of hospitals using that system. The uniform system provides the foundation for the collection and reporting of specific data on an annual and quarterly basis to OSHPD. The underlying objective of the reporting requirement is to provide the public, the hospital industry, and State policy makers accurate, uniform, and objective information regarding the revenues, expenses, assets, liabilities, equity, capacity, and utilization of California hospitals. As public

information, these data are and will continue to be available to officials at all levels of state and local government for their use in formulating and evaluating health system policies and in managing governmental health delivery programs. These data are also available to health care consultants, employers, insurers, organized labor, and other health care purchasers who may use the information to make informed decisions in today's health care market. Finally, the data are available to health service providers who may use the information for health facility management and strategic planning purposes.

The Manual is being revised to:

- update the payer categories by including payer categories for Medicare - Managed Care, Medi-Cal - Managed Care, County Indigent Programs - Managed Care, and Other Third Parties - Managed Care to accommodate hospitals' need for recording revenue, expenses, and statistics related to providing services to managed care patients;

- rename the current payer categories for Medicare, Medi-Cal, County Indigent Programs, and Other Third Parties to Medicare - Traditional, Medi-Cal - Traditional, County Indigent Programs - Traditional, and Other Third Parties - Traditional to better identify and distinguish these categories from managed care;

- add a payer category, Other Indigent, for indigent patients, excluding those recorded in the County Indigent Programs category and including those being provided charity care by the hospital, to separately identify services related to these patients;

- separate capitation premium revenue accounts from the deductions from revenue accounts to be consistent with Generally Accepted Accounting Principles (GAAP);

- eliminate the revenue account for purchased inpatient services since recording the revenue provides no meaningful information and distorts the calculations resulting from the cost allocation process;

- add an expense account for purchased outpatient services to separately identify these managed care services from managed care services provided within the hospital;

- eliminate managed care patient utilization statistics from Annual Disclosure Report page 3.3, item H, because managed care patient utilization data is being added in proposed new report page 4.1, Patient Utilization Statistics by Payor;

- revise Annual Disclosure Report page 4.1, Patient Census Statistics, and report page 4.2, Ambulatory, Ancillary, and Other Utilization Statistics, to eliminate the reporting of payer detail by cost center;

- combine Annual Disclosure Report pages 4.1 and 4.2 as report page 4 and title it as Patient Utilization Statistics to simplify reporting requirements;

- create new Annual Disclosure Report page 4.1, Patient Utilization Statistics by Payor, to accommodate the reporting of payer category detail for patient days and discharges by type of care, and payer category detail for outpatient visits by type of outpatient visit;

- change the display of operating expenses on Annual Disclosure Report page 8 from natural classification of expense to functional service to be consistent with GAAP;

- eliminate Annual Disclosure Report page 8.1 and combine the non-operating revenue and expense items on report page 8, Statement of Income, to simplify reporting requirements;

- revise Annual Disclosure Report page 12, Supplemental Patient Revenue Information, to accommodate the reporting of patient revenue information for the revised payer categories; and to eliminate the reporting of purchased inpatient services revenue;

- revise the Hospital Quarterly Financial and Utilization Report to reflect the proposed changes related to the revised payer categories, capitation premium revenue, and purchased inpatient and outpatient services;

- require each hospital to have the capability to use future versions of the Hospital Quarterly Reporting System (HQRS) software running under Windows 95 or later, or Windows NT operating systems; and

- make other minor or clarifying changes.

Expanded Payer Categories

Four managed care payer categories related to Medicare, Medi-Cal, County Indigent Programs, and Other Third Parties are being added to the Manual to separately account and report patient days, hospital discharges, outpatient visits, patient revenue, deductions from revenue, and capitation premium revenue for patients covered by managed care plans. Managed care patients are persons enrolled in a managed care plan to receive health care from hospitals on a pre-negotiated or per diem basis, usually involving utilization review (includes Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option (POS), etc.). Under the current Manual, all managed care data are included in the Other Third Parties payer category.

Also, a payer category, Other Indigent, is being added to the Manual to separately identify patient days, discharges, outpatient visits, and patient revenue for indigent patients, excluding those recorded in the County Indigent Programs category and including those being provided charity care by the hospital. Under the current Manual, all data related to these indigent patients are included in the Other Payors category.

After updating the payer categories in the Manual, the payer categories would be:

1) Medicare - Traditional includes patients covered by the Social Security Amendments of 1965 other than those covered by a managed care plan funded by Medicare. These patients are primarily the aged and needy.

2) Medicare - Managed Care includes patients who are covered by a managed care plan funded by Medicare. Medicare patients are covered by the Social Security Amendments of 1965 and are primarily the aged and needy.

3) Medi-Cal - Traditional includes patients who are qualified as needy under state laws other than those covered by a managed care plan funded by Medi-Cal.

4) Medi-Cal - Managed Care includes patients who are covered by a managed care plan funded by Medi-Cal. Medi-cal patients are those patients who are qualified as needy under state laws.

5) County Indigent Programs - Traditional includes indigent patients covered under Welfare and Institutions Code Section 17000 other than those covered by a managed care plan funded by a county. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources for which the hospital renders a bill or other claim for payment to a county. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered.

6) County Indigent Programs - Managed Care includes indigent patients covered under Welfare and Institution Code Section 17000 and are covered by a managed care health plan funded by a county.

7) Other Third Parties - Traditional includes all other forms of health coverage excluding managed care plans. Examples include indemnity plans, fee-for-service plans, Short-Doyle, Tricare (CHAMPUS), IRCA/SLIAG, California Children's Services, and Workers' Compensation.

8) Other Third Parties - Managed Care includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county.

9) Other Indigent includes indigent patients, excluding those recorded in the County Indigent Programs

category and including those being provided charity care by the hospital.

10) Other Payors includes all patients who are not included in the categories listed above, such as those designated as self-pay and U.C. teaching hospital patients who are provided care with Support for Clinical Teaching funds.

Because of the expansion in payer categories, accounts in the following areas were either added, renamed, or renumbered: patient receivables, allowance for contractual adjustments, patient revenue, deductions from revenue, and capitation premium revenue.

Patient Receivable Accounts and Allowance for Contractual Adjustments Accounts

Currently, patient receivable accounts and allowance for contractual adjustments accounts are separated between inpatient and outpatient by payer category using subaccounts. Due to limited available account numbers, inpatient and outpatient accounts are being combined to allow for expanded payer category detail.

Patient Revenue Accounts

The numeric coding system in the Chart of Accounts uses six digits. Account numbers include four digits to the left of the decimal point, which identify primary account classifications, and two digits to the right, which identify secondary account classifications (subclassifications). The subclassifications for patient revenue accounts must be revised to accommodate the revised payer categories.

The following tables show the current subclassifications of revenue and proposed subclassifications of revenue.

Current Subclassifications of Revenue

DECIMAL POINT	Digit	Patient Classification Description	Digit	Financial Status Classification Description
.	0	Inpatient	0	Self-Pay
.	1	Optional	1	HMO/PPO Contracts
.	2	Optional	2	Commercial Insurance
.	3	Optional	3	Workers' Compensation
.	4	Outpatient	4	Medicare
.	5	Optional	5	Medi-Cal
.	6	Optional	6	Short-Doyle
.	7	Optional	7	County Indigent Programs
.	8	Optional	8	Charity
.	9	Optional	9	Other

Proposed Subclassifications of Revenue

DECIMAL POINT	Digit	Patient Classification Description	Digit	Financial Status Classification Description
.	0	Inpatient - Traditional	0	Self-Pay
.	1	Inpatient - Managed Care	1	Not Assigned
.	2	Not Assigned	2	Private Coverage
.	3	Not Assigned	3	Workers' Compensation
.	4	Outpatient - Traditional	4	Medicare
.	5	Outpatient - Managed Care	5	Medi-Cal
.	6	Not Assigned	6	Other Government
.	7	Not Assigned	7	County Indigent Programs
.	8	Not Assigned	8	Other Indigent
.	9	Not Assigned	9	Other

Deductions from Revenue Accounts and Capitation Premium Revenue Accounts

To accommodate the revised payer categories, deduction from revenue accounts are either being added, renamed, or renumbered. Capitation premium revenue accounts are also being added and renumbered.

Report page 4.1, Patient Census Statistics; page 8, Statement of Income; and page 12, Supplemental Patient Revenue Information, of the Hospital Annual Disclosure Report forms have been revised to accommodate the reporting of financial and utilization data for the revised payer categories. The Hospital Quarterly Financial and Utilization Report also has been revised to accommodate the reporting of financial and utilization data for the revised payer categories.

Separate Capitation Premium Revenue from Deductions from Revenue

Capitation premium revenue related to the new managed care payer categories are being separated from and displayed after deductions from revenue on the Hospital Annual Disclosure Report and Hospital Quarterly Financial and Utilization Report. Although capitation premium revenue is being separated from deductions from revenue, capitation premium revenue will still be included in the net patient revenue.

Eliminate Revenue Account for Purchased Inpatient Services

The System of Accounts (Chapter 2000 of the Manual) is being changed to eliminate the revenue account for Purchased Inpatient Services (Account 4900). Recording the Purchased Inpatient Services revenue for managed care patients provides no meaningful information and distorts the calculations resulting from the cost allocation process. It is unnecessary for hospitals to record purchased inpatient services revenue for managed care patients since hospitals include revenue for these services in the capitation premium revenue account.

Add Expense Account for Purchased Outpatient Services

The System of Accounts (Chapter 2000 of the Manual) is being changed to add a cost center account for Purchased Outpatient Services (Account 7950) related to managed care patients. Under the current accounting and reporting system requirements, outpatient services purchased from another facility must be accounted and reported by functional cost center, i.e., Emergency Services, Clinical Laboratory Services, Magnetic Resonance Imaging, etc. This requires the hospitals purchasing outpatient services to obtain functional cost center detail from the facilities they are purchasing outpatient services from. By adding a cost center account for Purchased Outpatient Services (Account 7950) related to managed care patients, outpatient services purchased from another facility will be accounted and reported in one cost center, eliminating the need for functional cost center detail for purchased outpatient services.

The following Annual Disclosure Report forms are affected by the proposed addition of the Purchased Outpatient Services : report pages 8, and 17. Also, a new optional line is being added to the Hospital Quarterly Financial and Utilization Report related to purchased outpatient services expense.

Combine Annual Disclosure Report Pages 4.1 and 4.2 as Page 4

To reduce the reporting burden of expanded payer category detail, payer category detail by cost center is being eliminated from Hospital Annual Disclosure Report pages 4.1, Patient Census Statistics, and 4.2, Ambulatory, Ancillary, and Other Statistics. Average length of stay is also being eliminated from report page 4.1. The remainder of report pages 4.1 and 4.2 are being combined into new Annual Disclosure Report Page 4, Patient Utilization Statistics.

New Annual Disclosure Report Page 4.1

New Annual Disclosure Report Page 4.1, Patient Utilization Statistics by Payor, is being added to show payer category detail for patient days and hospital discharges by type of care, and for outpatient visits by type of outpatient visit.

Types of care are: acute care, psychiatric care, chemical dependency, rehabilitation care, long-term care, and other care. Separate lines showing patient days and hospital discharges by payer for nursery acute and purchased inpatient services are also included.

Types of outpatient visits are: emergency services (including psychiatric emergency room), clinics (including satellite clinics), observation care visits, psychiatric day-night care days, home health care services, hospice - outpatient, outpatient surgeries, private referred, and other.

Changes to Annual Disclosure Report Page 8

The display of operating expenses is being changed from showing expenses by natural classification to showing expenses by type of service. This change is proposed to provide for the reporting of expenses related to purchased inpatient services and purchased outpatient services, and will be consistent with Generally Accepted Accounting Principles.

Since the detail for deductions from revenue has increased with the addition of managed care payer categories, the detail for deductions from revenue will be displayed as a separate section on report page 8 after net income. The detail for capitation premium revenue will also be displayed as a separate section following the deductions from revenue detail.

Annual Disclosure Report page 8.1, Statement of Income - Unrestricted Fund (Non-Operating Revenue and Expense), is being eliminated and the non-operating revenue and expense detail is being combined with report page 8, Statement of Income - Unrestricted Fund so all income statement items are on one report page. The new section on report page 8 displaying non-operating revenue and expense detail will follow the section displaying capitation premium revenue detail. The non-operating revenue and expense lines were renumbered to make room for the deductions from revenue and capitation premium revenue detail.

Change the Hospital Quarterly Reporting System to be a Windows 95 Application

All California hospitals must complete and electronically transmit the Quarterly Financial and Utilization Report using the Hospital Quarterly Reporting System (HQRS) software. The Office provides the HQRS software to California hospitals. Currently, the HQRS software is a DOS-based personal computer (PC) application. However, because Windows 95 has become the standard operating system for IBM compatible PC's, DOS is no longer a viable operating system for most hospitals. Hospitals have also indicated difficulties in transmitting quarterly reports using the DOS-based HQRS software. Because of these limitations with the DOS-based HQRS software, the Office is converting the HQRS software to be a Windows 95-based PC application for quarters beginning January 1, 1999. Since hospitals must use the HQRS software to complete and transmit the Quarterly Financial and Utilization Report, each hospital must have the capability to use future versions of the Hospital Quarterly Reporting System (HQRS) software running under Windows 95 or later, or Windows NT operating systems for quarters beginning January 1, 1999.

CCR Section 97018, Accounting and Reporting Manual for California Hospitals

Section 97018 of Title 22, California Code of Regulations, is being amended to reflect the effective date of the above changes to the Second Edition of the Manual.

CCR Section 97041, Report Procedure

Section 97041 of Title 22, California Code of Regulations is being amended to update references to the Hospital Quarterly Reporting System, the Instructions and Specifications for Developing Approved Software to Submit the California Hospital Annual Disclosure Report on Personal Computer Diskette, and the Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 ¼" or 3 ½" IBM PC Compatible Diskette. Copies of the Instructions and Specifications for Developing Approved Software to Submit the California Hospital Annual Disclosure Report on Personal Computer Diskette, July 1997 issue, and the Instructions and Specifications for Submission of the California Long-term Care Facility Integrated Disclosure & Medi-Cal Cost Report on 5 ¼" or 3 ½" IBM PC Compatible Diskette, November 1997 issue, are available for public review at 818 K Street, Sacramento, CA 95814. To request viewing these documents, call the Office at (916) 323-1955.

FISCAL IMPACT ESTIMATES:

A. Estimate of Cost or Savings to Any State Agency (Cal. Gov't Code §11346.5(a)(6)): None.

B. Cost to Any Local Agency or School District That is Required to be Reimbursed by the State (Cal. Gov't Code §11346.5(a)(6)): None.

C. Non-Discretionary Cost or Savings Imposed on Local Agencies (Cal. Gov't Code §11346.5(a)(6)): None.

D. Cost or Savings in Federal Funding to the State (Cal. Gov't Code §11346.5(a)(6)): None.

E. Impact on Housing Costs (Cal. Gov't Code §11346.5(a)(11)): None.

F. Potential Cost Impact on Private Persons or Affected Business, Other Than Small Businesses (Cal. Gov't Code §11346.5(a)(9)): Based on a managed care payer category survey conducted by the Office, 19 percent of the hospitals responding indicated it would require an extreme effort or they would be unable to implement making changes to their accounting system to record managed care data by individual managed care plan. To modify their accounting systems to record managed care data, hospitals estimated the cost would range from $6,000 to $125,000 per facility.

DETERMINATIONS:

As required by Government Code Section 11346.5(a)(5), the Office has determined that the proposed Manual changes will impose requirements on all California hospitals, and will only incidentally affect government hospitals. There is no local mandate created by proposed revisions which would require state reimbursement required by Part 7 (commencing with Section 17500) of Division 4 of the Government Code. County of Los Angeles v. State of California (1987) 43 Cal.3d 46, 57-58.

As required by Government Code Section 11346.5(a)(8), the Office has determined that the proposed Manual changes would not have a significant adverse economic impact on businesses, including the ability of California businesses to compete with businesses in other states.

Pursuant to Government Code Section 11346.3(b)(1), the Office has determined that the proposed amendments would not significantly affect the following:

(1) The creation or elimination of jobs within the State of California.

(2) The creation of new businesses or the elimination of existing businesses within the State of California.

(3) The expansion of businesses currently doing business within the State of California.

As required by Section 4 of Title 1 of the California Code of Regulations, the Office has determined that the regulations will not affect small businesses as defined in Government Code Section 11342 (h). All affected hospitals either have annual gross receipts exceeding $1,500,000, or are not independently owned and operated.

AVAILABILITY OF STATEMENT OF REASONS AND TEXT OF REGULATIONS:

The Office prepared an Initial Statement of Reasons for the proposed Manual changes and related regulations. This statement, the text of the proposed changes (in Italic and strikeout format), and the information in support of the proposed changes are available from the Office at the address indicated above (see Contact Person). In addition, the Initial Statement of Reasons and text of the proposed changes will be mailed to all California-licensed hospitals.

AVAILABILITY OF CHANGED OR MODIFIED TEXT:

After the close of the public comment period or at the end of the public hearing, if one is requested and held, the Office may, without further notice, adopt the regulatory changes as proposed or adopt them with nonsubstantial or grammatical changes as it deems appropriate. If the Office intends to adopt the regulations with modifications, other than nonsubstantial or grammatical changes, the full text of the modified regulations will be made available to the public at least 15 days before they are adopted. A request for copies of modified regulations should be submitted to the Contact Person at the address noted above.

ALTERNATIVES

According to Government Code Section 11346.5(a)(12) the Office must determine that no alternative considered by the Office would be more effective in carrying out the purpose for which the action is proposed or less burdensome to affected private persons than the proposed action.

Office of Statewide Health Planning and Development

Dated: June 2, 1998

Jay R. Benson, Manager
Accounting and Reporting Systems Section